DCC-95A
(R. 05/08)

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care

N

Health Statement

Name (First, Middle, Last) | Date of Birth | Phone

Address: Street | City | Zip Code | State

Check one of the following that applies to you:
Applicant (question 1-6) ☐ Adult household member of applicant (question 6 only) ☐

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize the release of this information for the limited purpose of my application as a child care provider.

Signature of the Child Care Applicant or adult household member of child care applicant | Date

THIS SECTION TO BE COMPLETED BY THE HEALTH CARE PROFESSIONAL

As part of the application process for approval as a child care provider, a statement from a physician, physician's assistant, advanced registered nurse practitioner, or registered nurse under the supervision of a physician, is required to address the following:

Questions 1-5 apply to the applicant only.

1. Do you have reason to believe the applicant has a communicable or infectious disease that would present a health or safety risk to a child placed in the applicant's care? ☐**YES** ☐**NO**
2. Has the applicant previously had or does the applicant currently have a medical condition that would present a health or safety risk to a child placed in the applicant's care? ☐**YES** ☐**NO**
3. Does the applicant have a physical limitation, mental illness, alcohol or drug problem, significant history of physical or mental illness, or other health condition that would interfere with the applicant's ability to provide child care? ☐**YES** ☐**NO**
4. Does the applicant currently take prescription medication that would interfere with the applicant's ability to provide child care? ☐**YES** ☐**NO**
5. Would responsibility for a child or children pose a potential risk to the applicant's health? ☐**YES** ☐**NO**

Question 6 applies to the applicant and other adult household member.

6. The applicant (or other adult household member) is free of active tuberculosis? ☐**YES** ☐**NO**

Physician's/Health Care Professional's Signature or Stamp | Title | Date

Address | Phone Number